Enrollment / Change Form

Employer: Complete Section A
Employee: Complete Sections B-G

Please print and thank you for providing this information

Insured and/or Administered by
Connecticut General Life Insurance Company
900 Cottage Grove Rd.
Hartford, CT 06152-1038

CIGNA®

A

☐ Open Enroll. ☐ Change ☐ New Enroll. ☐ Reinstate

Effective Date of Add/Change/ Cancellation (MM/DD/CCYY)	Employer Name	Employer Address

CIGNA Account No.	Division/Branch/Location/Class	Date of Hire (MM/DD/CCYY)	Network ID	Branch Code	CDH Group No.	Medical Benefit Option	Dental Benefit Option	CIGNA Choice Fund Annual Amount

TYPE OF CHANGE:

☐ **Add Dependent(s) *** Date: _____
☐ **Cancel Employee** Last Date of Coverage: _____
☐ **Cancel Dependent(s) *** Last Date of Coverage: _____
*** List Names in Section B**

☐ **Address Change**
☐ **Transfer to COBRA**
☐ 18 mos. ☐ 29 mos. ☐ 36 mos.

☐ **Family Security Benefit/Surviving Spouse**
☐ **Retirement**
☐ **Other** _____

B

Employee Name *(Last)*	*(First)*	*(M.I.)*	Social Security No.	Employee Date of Birth (MM/DD/DDYY)	Employee Identification Number

Home Phone ( )	Work Phone ( )	Home E-Mail Address	Address *(Street)*	*(City)*	*(State)*	*(Zip Code)*

I Would Like Coverage For Me and My Dependents. ***(Specify last name if different from yours)*** **Last Name First Name M.I.**	**Dependent Social Security No.**	**Date of Birth MM DD CCYY**	**Gender**	**Coverage Selection**	**Full Time Student? * Yes No**	***If you choose a Managed Care Medical Option: Select your choice of Primary Care Physician (PCP) or HealthCare Center (HCC) and enter the ID Numbers below. Note: PCP selection is optional for Open Access Plans.***	**Existing Patient? Yes No**	***(check one)***
Employee			☐ M ☐ F	☐ Medical ☐ Dental		PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Spouse			☐ M ☐ F	☐ Medical ☐ Dental		PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel
Dependent * Relationship			☐ M ☐ F	☐ Medical ☐ Dental	☐ ☐	PCP or HCC Choice -	☐ ☐	☐ Add ☐ Cancel

*** DEPENDENTS -** If full time student and age 19 or over, attach proof verifying credit hours. If totally disabled prior to age 19, attach proof of disability for eligibility review.

C

MANAGED CARE MEDICAL OPTIONS:
☐ Point-of-Service (DPP)
☐ Point-of-Service Open Access (DPP)

OTHER MEDICAL OPTIONS:
☐ Open Access Plus
☐ Preferred Provider Option (PPO)
☐ Preferred Provider Access (PPA)
☐ Medical Indemnity
☐ _____

SOLD TO SELF-FUNDED GROUPS ONLY:
☐ Network (or EPP) **(ASO)**
☐ Network Open Access **(ASO)**
☐ In-Network PPO or EPO **(ASO)**
☐ Open Access Plus In-Network **(ASO)**

CIGNA CHOICE FUND℠ OPTIONS:
☐ HRA
☐ HSA
☐ Pharmacy HRA
☐ Dental HRA
☐ with PPO
☐ with Open Access Plus
☐ with Open Access Plus In-Network **(ASO)**
☐ with EPO **(ASO)**
☐ with Indemnity

☐ CIGNA Care Network
☐ Decline Coverage

OPTION # *(if applicable):*
☐ 1 ☐ 2 ☐ 3

If you choose a Managed Care Medical Option, print the name of the CIGNA HealthCare Network. (See the cover or first page of the physician guide). Include the name of the city and state.

CIGNA HealthCare of (city / state):

D

FLEXIBLE SPENDING ACCOUNT OPTIONS:
☐ Health Care*
☐ Dependent Day Care*
☐ Decline Coverage

E

DENTAL OPTIONS:
☐ Dental PPO
☐ Dental Indemnity
☐ Decline Coverage

*If you have checked off one of the Flexible Spending Accounts in Section D, please make sure you have completed the corresponding enrollment form included in this package.

F

OTHER HEALTH CARE COVERAGE:
Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No *If yes, please provide the following:*

Name of Person Covered	Social Security No.	Effective Date	Medicare Part A	Medicare Part B	Medicaid	Other Insurance Carrier
			☐	☐	☐	☐
			☐	☐	☐	☐

G

SIGNATURE - The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

Employee's Signature / Date	Spouse's Signature / Date	Employer's Signature / Date

IMPORTANT! BEFORE YOU WRITE ON THIS SIDE: DETACH THIS PAGE BEFORE COMPLETING SECTIONS H AND I

Employee: Complete Sections H-I if applicable

H

LIFE AND AD&D	EMPLOYEE	DEPENDENT	LIFE AND AD&D	EMPLOYEE	DEPENDENT	STD AND LTD	EMPLOYEE
☐ Life	$		☐ Dependent Life - Child(ren)		$	☐ Short Term Disability (STD)	$
☐ Additional Life	$		☐ Accidental Death & Dismemberment (AD&D)	$		☐ Long Term Disability (LTD)	$
☐ Dependent Life - Spouse		$	☐ Additional AD&D	$		Decline Coverage: ☐ LIFE ☐ AD&D ☐ STD ☐ LTD	

I

IF YOU ELECT LIFE OR AD&D BENEFITS, INDICATE YOUR BENEFICIARY BELOW.

BENEFICIARY NAME *(Last)* *(First)* *(M.I.)*	RELATIONSHIP	% OF INSURANCE

IMPORTANT: If you have chosen medical coverage and your employer is providing Life and/or AD&D coverage, please forward a copy of this page, along with the first ply of this form as your employer directs.

PROVISIONS

- "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.
- I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person to fully inform the healthplan and will execute such assignments, liens or other documents which may be necessary to enable the healthplan to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the healthplan, I will immediately reimburse the healthplan to the extent of services provided, to the extent permitted by state law.

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISION FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the Insurance Plan other than during the open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not waive any terms of its contract. Further, by allowing an individual to enroll in the Insurance Plan other than during an open enrollment period, CIGNA HealthCare or Connecticut General Life Insurance Company does not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.

SPECIAL STATE PROVISION

Mid-Atlantic: If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member services representative before signing this application or card. You or your representative are entitled to receive a copy of this form. A referral from the enrollee's Primary Care Physician is not required for medically necessary gynecological care received from a network gynecologist or certified nurse mid-wife, emergency, out-of-area urgent care, or out of network care received under the Point of Service option.